### Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

► Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos. 1210-0110 1210-0089

2012

This Form is Open to Public Inspection

Part I	Annual Report Identif	ication Information						
For cale	For calendar plan year 2012 or fiscal plan year beginning 01/01/2012 and ending 12/31/2012							
<b>A</b> This	return/report is for:	a multiemployer plan;	a multiple	e-employer plan; or				
A IIIIS	return/report is for.							
a single-employer plan; a DFE (specify)								
			п					
<b>B</b> This	return/report is:	the first return/report;	the final	return/report;				
		an amended return/report;	a short p	lan year return/report (les	s than 12 m	onths).		
C If the	plan is a collectively bargained r	olan, check here	ш .			<b>.</b> П		
			_					
<b>D</b> Chec	k box if filing under:	Form 5558;	automati	c extension;	X th	e DFVC program;		
		special extension (enter des	cription)					
Part	II Basic Plan Informat	tion—enter all requested informa	ation					
	ne of plan	ion cher all requested illiente	20011		1h	Three-digit plan		
	) EMPLOYEE HEALTH & WELF	ADE DI ANI			15	number (PN) > 501		
IVAAOO	DEIVILLOTEE HEALTITA WELL	AIL I LAIN			1c	Effective date of plan		
						09/01/1992		
<b>2a</b> Plar	sponsor's name and address: ir	nclude room or suite number (emp	olover if for a single-	employer plan)	2h	Employer Identification		
<b>_</b> a    a	i openicor o name ana adarece, ii	Totale Teem of Sale Tramber (Smp	oloyor, ii ror a olingio	omproyor plany		Number (EIN)		
KAASC	) INC					91-1226395		
	AILORED				2c	Sponsor's telephone		
TVAAO 1	AILORED					number		
40000 D						425-743-1886		
	EVERLY PARK ROAD, SUITE A EO, WA 98275		VERLY PARK ROAI O, WA 98275	D, SUITE A	2d	Business code (see		
WORLL	20, 111 30270	WORLETE	O, WA 30213			instructions)		
						337000		
Caution	: A penalty for the late or incor	mplete filing of this return/repor	rt will be assessed	unless reasonable caus	e is establi	shed.		
Under po	enalties of perjury and other pena	alties set forth in the instructions, I	I declare that I have	examined this return/repo	rt, including	accompanying schedules,		
stateme	nts and attachments, as well as t	he electronic version of this return	n/report, and to the b	est of my knowledge and	belief, it is t	rue, correct, and complete.		
SIGN	Filed with authorized/valid elect	ronio gignoturo	01/08/2015	BRENDA WRIGHT				
HERE			01/00/2013					
	Signature of plan administra	tor	Date	Enter name of individua	al signing as	plan administrator		
SIGN	Filed with authorized/valid elect	ronic signature.	01/08/2015	TYLER HAGENS				
HERE	Signature of employer/plan s	enoneor	Date	Enter name of individua	l cianina ac	employer or plan sponsor		
	Signature of employer/plan s	ропзог	Date	Litter flame of individua	ii sigiiiiig as	employer of plant sponsor		
CION								
SIGN HERE								
IILKL	Signature of DFE		Date	Enter name of individua	al signing as	DFE		
Prepare	's name (including firm name, if	applicable) and address; include r	room or suite numbe	r. (optional)	Preparer's	telephone number		
					(optional)			

Form 5500 (2012) Page **2** 

If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name.   Ab EIN	3a	Plan administrator's name and address Same as Plan Sponsor Name	Same as Pla	an Spo	nsor Address	<b>3b</b> Admini	strator's EIN
EIN and the plan number from the last return/report:  a Sponsor's name  5 Total number of participants at the beginning of the plan year  6 Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d).  a Active participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d).  b Retired or separated participants receiving benefits							
EIN and the plan number from the last return/report:  a Sponsor's name  5 Total number of participants at the beginning of the plan year  6 Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d).  a Active participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d).  b Retired or separated participants receiving benefits							
5 Total number of participants at the beginning of the plan year 6 Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d).  a Active participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d).  b Retired or separated participants receiving benefits.  c Other retired or separated participants entitled to future benefits.  d Subtotal. Add lines 6a, 6b, and 6c.  e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.  f Total. Add lines 6d and 6e.  g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item).  g Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested.  T Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item).  7 In Jair If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:  b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:  4A 4B 4D 4E  9a Plan funding arrangement (check all that apply)  (1)	4		/report filed	for this	plan, enter the name,	4b EIN	
6 Number of participants as of the end of the plan year (welfare plans complete only lines 6a, 6b, 6c, and 6d).  a Active participants	а	Sponsor's name				4c PN	
a Active participants	5	Total number of participants at the beginning of the plan year				5	116
b Retired or separated participants receiving benefits	6	Number of participants as of the end of the plan year (welfare plans complete	e only lines 6	a, 6b,	<b>6c,</b> and <b>6d</b> ).		
c Other retired or separated participants entitled to future benefits	а	Active participants				6a	121
d Subtotal. Add lines 6a, 6b, and 6c	b	Retired or separated participants receiving benefits				6b	1
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	С	Other retired or separated participants entitled to future benefits				6c	
f Total. Add lines 6d and 6e	d	Subtotal. Add lines 6a, 6b, and 6c.				6d	122
Some possible this item)	е	Deceased participants whose beneficiaries are receiving or are entitled to rec	ceive benefit	s		6e	
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	f	Total. Add lines 6d and 6e.				6f	122
less than 100% vested	g					6g	
Ba If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:    b   If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:   4A	h					6h	
b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:  4A 4B 4D 4E  9a Plan funding arrangement (check all that apply)  (1)	7	Enter the total number of employers obligated to contribute to the plan (only n	multiemploye	er plans	s complete this item)	7	
(1)   Insurance   (2)   Code section 412(e)(3) insurance contracts   (2)   Code section 412(e)(3) insurance contracts   (3)   Trust   (4)   General assets of the sponsor   (4)   X General assets of the sponsor   (4)   X General assets of the sponsor   (4)   X General assets of the sponsor   (5)   General assets of the sponsor   (6)   X General assets of the sponsor   (7)   X General assets of the sponsor   (8)   X General assets of the sponsor   (9)   X General assets of the sponsor   (1)   X General assets of the sponsor   (1)   X General assets of the sponsor   (2)   X General assets of the sponsor   (3)   X General assets of the sponsor   (4)   X General assets of the sponsor   (5)   X General assets of the sponsor   (6)   X General assets of the sponsor   (7)   X General assets of the sponsor   (8)   X General assets of the sponsor   (9)   X General assets of the sponsor   (9)   X General assets of the sponsor   (1)   X General assets of the sponsor   (2)   X General assets of the sponsor   (3)   X General assets of the sponsor   (4)   X General assets of the sponsor   (5)   X General assets of the sponsor   (6)   X General assets of the sponsor   (7)   X General assets of the sponsor   (8)   X General assets of the sponsor   (1)   X General assets of the sponso		If the plan provides welfare benefits, enter the applicable welfare feature code					
a Pension Schedules (1) R (Retirement Plan Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) SB (Single-Employer Defined Benefit Plan Actuarial (5) General Schedules (1) H (Financial Information) (2) I (Financial Information – Small Plan) (3) X 2 A (Insurance Information) (4) X C (Service Provider Information) D (DFE/Participating Plan Information)	9a	(1) X Insurance (2) Code section 412(e)(3) insurance contracts (3) Trust	(1) (2) (3)	penefit :	Insurance Code section 412(e)(3) Trust	insurance co	ontracts
(1) R (Retirement Plan Information) (1) H (Financial Information) (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (3) SB (Single-Employer Defined Benefit Plan Actuarial (5) D (DFE/Participating Plan Information)	10	Check all applicable boxes in 10a and 10b to indicate which schedules are at	ttached, and	, where	e indicated, enter the num	ber attached	. (See instructions)
(1) H (Financial Information)  (2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary  (3) X Z A (Insurance Information)  (4) X C (Service Provider Information)  (5) D (DFE/Participating Plan Information)	а		b Gene	ral Scl	nedules		
Purchase Plan Actuarial Information) - signed by the plan actuary  (3)		(1) R (Retirement Plan Information)	(1)		H (Financial Infor	mation)	
(e)		Purchase Plan Actuarial Information) - signed by the plan	(3)	X	_2 A (Insurance Info	rmation)	·
						_	

## **SCHEDULE A** (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

**Insurance Information** 

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

Insurance companies are required to provide the information

OMB No. 1210-0110

2012

						orm is Open to Public Inspection		
For calendar plan year 20	12 or fiscal pla	an year beginning 01/01/2012	2	and endir	ng 12/31/2012			
A Name of plan KAASCO EMPLOYEE HE	ALTH & WEL	FARE PLAN	E		digit umber (PN)	501		
KAASCO, INC	C Plan sponsor's name as shown on line 2a of Form 5500  KAASCO, INC  D Employer Identification Number (EIN) 91-1226395							
		ning Insurance Contract. Individual contracts grouped a						
1 Coverage Information:								
(a) Name of insurance ca	rrier							
UNION SECURITY INSU	RANCE COM	1PANY						
/b) FIN	(c) NAIC	(d) Contract or	(e) Approximate num		Policy o	r contract year		
<b>(b)</b> EIN	code	identification number	persons covered at e policy or contract ye		(f) From	<b>(g)</b> To		
81-0170040	70408	5412705	121		01/01/2012	12/31/2012		
2 Insurance fee and com- descending order of the		nation. Enter the total fees and t	otal commissions paid. List	in line 3 the	e agents, brokers, and	d other persons in		
(a) Total amount of commissions paid (b) Total amount of fees paid								
2150								
3 Persons receiving com	missions and	fees. (Complete as many entrie	es as needed to report all pe	rsons).				
LID DECOLIDOES	(a) Name	and address of the agent, broke	er, or other person to whom or BOX 1537	commission	ns or fees were paid			
HR RESOURCES			OHOMISH, WA 98291					
(b) Amount of sales ar	nd base	F	ees and other commissions	paid				
commissions pa		(c) Amount	(d)	Purpose		(e) Organization code		
	2150	0				3		
	(a) Name	and address of the agent, broke	er or other person to whom o	commission	ns or fees were paid			
	(a) Hamo	and address of the agont, broke	n, or ourer percent to when t		io di 1000 Wolo paid			
(b) Amount of sales ar	nd base	F	ees and other commissions	paid				
commissions pa		(c) Amount	(d)	Purpose		(e) Organization code		

Schedule A (Form 5500)	2012	Page <b>2 -</b> 1						
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid					
	,	.,,						
(b) Amount of color and bose		Fees and other commissions paid	(a) Organization					
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code					
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid					
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization					
commissions paid	(c) Amount	(d) Purpose	code					
( ) ) !			• • • • • • • • • • • • • • • • • • • •					
<b>(a)</b> Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid					
	T		<u> </u>					
(b) Amount of sales and base	(-) A	Fees and other commissions paid	(e) Organization					
commissions paid	(c) Amount	(d) Purpose	code					
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid					
	, , , , , , , , , , , , , , , , , , ,							
(h) Amount of color and bose		Fees and other commissions paid	(2) Orner in eties					
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code					
•	, ,							
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid					
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization					
commissions paid	(c) Amount	(d) Purpose	code					

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Part II		Investment and Annuity Contract Information  Where individual contracts are provided, the entire group of such indivi	Investment and Annuity Contract Information  Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of					
		this report.						
		ent value of plan's interest under this contract in the general account at year						
5	Curre	ent value of plan's interest under this contract in separate accounts at year e	nd		5			
6		racts With Allocated Funds:						
	а	State the basis of premium rates						
		Premiums paid to carrier			6b			
		Premiums due but unpaid at the end of the year			6c			
		If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d			
		Specify nature of costs						
	е	Type of contract: (1) individual policies (2) group deferred	d annuity					
		(3) other (specify)						
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan o	heck here				
7	Contr	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	separate accounts)				
	а	Type of contract: (1) deposit administration (2) immedia	ite participa	tion guarantee				
		(3) ☐ guaranteed investment (4) ☐ other ▶						
		(e) [] 3						
	b	Balance at the end of the previous year			7b			
		Additions: (1) Contributions deposited during the year	. 7c(1)					
		(2) Dividends and credits	. 7c(2)					
		(3) Interest credited during the year	. 7c(3)					
		(4) Transferred from separate account	. 7c(4)					
		(5) Other (specify below)	. 7c(5)					
		(6)Total additions			7c(6)			
	d∃	Total of balance and additions (add lines 7b and 7c(6))	<u>.</u>	<u></u>	7d			
	e [	Deductions:						
	(	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)					
	(	(2) Administration charge made by carrier	. 7e(2)					
	(	(3) Transferred to separate account	. 7e(3)					
	(	(4) Other (specify below)	. 7e(4)					
		•						
	,	(E) Total deductions			7e(5)			
		(5) Total deductions						
		Dalance at the end of the current year (Subtract line re(3) from line rd)			/ 1			

Schedule A (Form 5500) 2012		Page <b>4</b>		
If more than one contract covers the same information may be combined for reporting the entire group of such individual contract.	e group of employees of the sa g purposes if such contracts ar	re experience-rated as a u	nit. Where contrac	
Benefit and contract type (check all applicable box	es)			
<b>a</b> Health (other than dental or vision)	<b>b</b> Dental	<b>c</b> Vision		<b>d</b> X Life insurance
e Temporary disability (accident and sickness	s) <b>f</b> Long-term disability	g Supplementa	l unemployment	h Prescription drug
i Stop loss (large deductible)	j HMO contract	k PPO contrac		I  Indemnity contract
	j 🔲 milo comilaci	<b>K</b> □ 11 0 00mma0	,	I I Indominity contract
m ☐ Other (specify)				
Experience-rated contracts:				
Premiums: (1) Amount received		9a(1)		1
(2) Increase (decrease) in amount due but un		9a(2)		7
(3) Increase (decrease) in unearned premium	· —	9a(3)		7
(4) Earned ((1) + (2) - (3))			9a(4)	
<b>b</b> Benefit charges (1) Claims paid		9b(1)	<u> </u>	
(2) Increase (decrease) in claim reserves		9b(2)		
(3) Incurred claims (add (1) and (2))			9b(3)	
(4) Claims charged			9b(4)	
<b>c</b> Remainder of premium: (1) Retention charge	s (on an accrual basis)			
(A) Commissions		9c(1)(A)		
(B) Administrative service or other fees		9c(1)(B)		
(C) Other specific acquisition costs		9c(1)(C)		
(D) Other expenses		9c(1)(D)		

9c(1)(H)

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

15574

retention of the contract or policy, other than reported in Part I, line 2 above, report amount..... Specify nature of costs

**10** Nonexperience-rated contracts:

Part III

(E) Taxes..... (F) Charges for risks or other contingencies .....

(H) Total retention .....

(2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.) ......

(2) Claim reserves

(3) Other reserves Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....

Total premiums or subscription charges paid to carrier ...... If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement......

Part IV	Provision of Information			
<b>11</b> Did t	ne insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	_

9c(1)(E)

9c(1)(F)

<sup>12</sup> If the answer to line 11 is "Yes," specify the information not provided.

## **SCHEDULE A** (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

## **Insurance Information**

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

#### File as an attachment to Form 5500.

OMB No. 1210-0110

2012

r ension benefit duaranty oc	riporation	Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).				This Form is Open to Public Inspection	
For calendar plan year 20	12 or fiscal pla	an year beginning 01/01/2012	2	and en	ding 12/3	1/2012	
A Name of plan KAASCO EMPLOYEE HE	ALTH & WEL	FARE PLAN		B Three plan	e-digit number (PN)	<b>•</b>	501
C Plan sponsor's name as shown on line 2a of Form 5500  KAASCO, INC  D Employer Identification Number 91-1226395						tion Number	(EIN)
		ning Insurance Contrac . Individual contracts grouped a					
(a) Name of insurance ca		CE COMPANY					
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate not persons covered a policy or contract	t end of	(f) F	Policy or c	ontract year (g) To
59-1031071	67369	00607723	, ,	25	04/01/201	2	12/31/2012
2 Insurance fee and com descending order of the		nation. Enter the total fees and t	otal commissions paid. L	ist in line 3 t	the agents, b	rokers, and c	other persons in
		nmissions paid		<b>(b)</b> To	tal amount of	fees paid	
2		0					0
3 Persons receiving com		fees. (Complete as many entried and address of the agent, broke					
<b>(b)</b> Amount of sales ar			ees and other commissio			. or o paid	
commissions pa		(c) Amount		(d) Purpose	9		(e) Organization code
	(a) Name	and address of the agent, broke	er, or other person to who	m commissi	ions or fees w	vere paid	
		<u> </u>				•	
(b) Amount of sales ar	nd base	F	ees and other commission	ns paid			
commissions pa		(c) Amount		(d) Purpose	Э		(e) Organization code

Schedule A (Form 5500)	2012	Page <b>2 -</b> 1						
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid					
	,	.,,						
(b) Amount of color and bose		Fees and other commissions paid	(a) Organization					
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code					
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid					
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization					
commissions paid	(c) Amount	(d) Purpose	code					
( ) ) !			• • • • • • • • • • • • • • • • • • • •					
<b>(a)</b> Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid					
	T		<u> </u>					
(b) Amount of sales and base	(-) A	Fees and other commissions paid	(e) Organization					
commissions paid	(c) Amount	(d) Purpose	code					
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid					
	, , , , , , , , , , , , , , , , , , ,							
(h) Amount of color and bose		Fees and other commissions paid	(2) Orner institut					
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	(e) Organization code					
•	, ,							
(a) Na	ame and address of the agent, broke	er, or other person to whom commissions or fees were pa	aid					
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization					
commissions paid	(c) Amount	(d) Purpose	code					

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Part II		Investment and Annuity Contract Information  Where individual contracts are provided, the entire group of such indivi	Investment and Annuity Contract Information  Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of					
		this report.						
		ent value of plan's interest under this contract in the general account at year						
5	Curre	ent value of plan's interest under this contract in separate accounts at year e	nd		5			
6		racts With Allocated Funds:						
	а	State the basis of premium rates						
		Premiums paid to carrier			6b			
		Premiums due but unpaid at the end of the year			6c			
		If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount			6d			
		Specify nature of costs						
	е	Type of contract: (1) individual policies (2) group deferred	d annuity					
		(3) other (specify)						
	f	If contract purchased, in whole or in part, to distribute benefits from a termin	ating plan o	heck here				
7	Contr	racts With Unallocated Funds (Do not include portions of these contracts ma	intained in s	separate accounts)				
	а	Type of contract: (1) deposit administration (2) immedia	ite participa	tion guarantee				
		(3) ☐ guaranteed investment (4) ☐ other ▶						
		(e) [] 3						
	b	Balance at the end of the previous year			7b			
		Additions: (1) Contributions deposited during the year	. 7c(1)					
		(2) Dividends and credits	. 7c(2)					
		(3) Interest credited during the year	. 7c(3)					
		(4) Transferred from separate account	. 7c(4)					
		(5) Other (specify below)	. 7c(5)					
		(6)Total additions			7c(6)			
	d∃	Total of balance and additions (add lines 7b and 7c(6))	<u>.</u>	<u></u>	7d			
	e [	Deductions:						
	(	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)					
	(	(2) Administration charge made by carrier	. 7e(2)					
	(	(3) Transferred to separate account	. 7e(3)					
	(	(4) Other (specify below)	. 7e(4)					
		•						
	,	(E) Total deductions			7e(5)			
		(5) Total deductions						
		Dalance at the end of the current year (Subtract line re(3) from line rd)			/ 1			

	Schedule A (Form 5500) 2012		Page <b>4</b>		
art III	Welfare Benefit Contract Informa If more than one contract covers the same g information may be combined for reporting p the entire group of such individual contracts	roup of employees of the surposes if such contracts a	are experience-rated	d as a unit. Where contract	
Benef	it and contract type (check all applicable boxes)	)			
a X	Health (other than dental or vision)	<b>b</b> Dental	C X Vision	1	<b>d</b> Life insurance
е 🗍	Temporary disability (accident and sickness)	f Long-term disability	y <b>g</b> Suppl	lemental unemployment	h Prescription drug
i П	Stop loss (large deductible)	j HMO contract	=		I Indemnity contract
m□	Other (specify)	, I mile contidet		sonitati	
m _	Other (specify)				
Experi	ence-rated contracts:				
•	remiums: (1) Amount received		9a(1)		
(2	2) Increase (decrease) in amount due but unpai	d	9a(2)		
(3	B) Increase (decrease) in unearned premium re	serve	9a(3)		
(4	4) Earned ((1) + (2) - (3))			9a(4)	
<b>b</b> E	Benefit charges (1) Claims paid		9b(1)		
(2	2) Increase (decrease) in claim reserves		9b(2)		
(3	3) Incurred claims (add (1) and (2))			9b(3)	
(4	4) Claims charged			9b(4)	
<b>C</b> F	Remainder of premium: (1) Retention charges (	on an accrual basis)			
	(A) Commissions		9c(1)(A)		
	(B) Administrative service or other fees		9c(1)(B)		
	(C) Other specific acquisition costs		9c(1)(C)		
	(D) Other expenses		9c(1)(D)		
	(E) Taxes		9c(1)(E)		

9c(1)(H)

9c(2)

9d(1)

9d(2) 9d(3)

9e

10a

10b

retention of the contract or policy, other than reported in Part I, line 2 above, report amount...... Specify nature of costs

10 Nonexperience-rated contracts:

(F) Charges for risks or other contingencies .....

(H) Total retention ..... (2) Dividends or retroactive rate refunds. (These amounts were paid in cash, or credited.) ......

**d** Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement......

(2) Claim reserves

(3) Other reserves ..... Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....

Total premiums or subscription charges paid to carrier ...... If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or

Part III

Part IV	Provision of Information				
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	X	Yes	No	

9c(1)(F)

<sup>12</sup> If the answer to line 11 is "Yes," specify the information not provided. SCHEDULE WAS NOT RECEIVED IN THE MAIL.

# SCHEDULE C (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration Pension Benefit Guaranty Corporation **Service Provider Information** 

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ File as an attachment to Form 5500.

OMB No. 1210-0110

2012

This Form is Open to Public Inspection.

For calendar plan year 2012 or fiscal plan year beginning	01/01/2012		and ending 12/31/2012	
A Name of plan KAASCO EMPLOYEE HEALTH & WELFARE PLAN		В	Three-digit plan number (PN)	501
			plan number (1 14)	
C Plan sponsor's name as shown on line 2a of Form 550		D	Employer Identification Nu	mbor (EINI)
KAASCO, INC	JU	D	. ,	mber (EIIV)
NAAGOO, INC			91-1226395	
Part I Service Provider Information (see	instructions)			
,	,			
You must complete this Part, in accordance with the in or more in total compensation (i.e., money or anything	•		-	
plan during the plan year. If a person received <b>only</b> el				
answer line 1 but are not required to include that person	on when completing the remain	nder of this	Part.	
1 Information on Persons Receiving Only	Eligible Indirect Comp	ensation		
a Check "Yes" or "No" to indicate whether you are exclude	•			nly eligible
indirect compensation for which the plan received the	required disclosures (see instre	uctions for o	definitions and conditions)	Yes X No
<b>b</b> If you answered line 1a "Yes," enter the name and El	IN or address of each person r	aroviding the	a required disclosures for the	service providers who
received only eligible indirect compensation. Complete				service providers who
(b) Enter name and EIN or ac			sures on eligible indirect com	pensation
CIGNA HEALTH AND LIFE INSURANCE COM	1601 CHESTNUT STR PHILADELPHIA, PA 19			
50.4004074				
59-1031071				
<b>(b)</b> Enter name and EIN or a	ddress of person who provided	d you disclo	sure on eligible indirect comp	pensation
UNION SECURITY INSURANCE COMPANY	2323 GRAND BOULEV		·	
	KANSAS CITY, MO 64	1108		
81-0170040				
(b) Enter name and EIN or ad	dress of person who provided	l vou disclos	ures on eligible indirect com	pensation
(2) 2.113. 114.115 4.11 2.11 5.1 45		, , o u u.o o.o o		
(b) Fatar ages and Fibbons	dan an af managa saha masa 2 da d			
(b) Enter name and EIN or ad	aress of person who provided	you aisclos	ures on eligible indirect com	pensation

Schedule C (Form 5500) 2012	Pa	age <b>2-</b> 1	
(b) Enter name and FIN or a	address of person who provided vo	ou disclosures on eligible indirect co	mpensation
(1) -110			
(b) Enter name and EIN or a	address of person who provided yo	ou disclosures on eligible indirect co	mpensation
	<u></u>	<del>-</del>	<u>·</u>
(b) Enter name and EIN or a	ddress of person who provided yo	ou disclosures on eligible indirect co	mpensation
(b) Enter name and EIN or a	ddress of person who provided yo	u disclosures on eligible indirect cor	mpensation
(h) =			
(D) Enter name and EIN or a	ddress of person who provided yo	ou disclosures on eligible indirect co	mpensation
(b) Enter name and EIN or a	ddress of person who provided vo	ou disclosures on eligible indirect co	mpensation
(1) -110			
(b) Enter name and EIN or a	ddress of person who provided yo	ou disclosures on eligible indirect co	mpensation
(b) Enter name and EIN or a	ddress of person who provided yo	ou disclosures on eligible indirect co	mpensation

	Schedule C (Form 550	00) 2012		Page <b>3 -</b> 1		
answered	I "Yes" to line 1a above	e, complete as many	entries as needed to list ea	or Indirect Compensation ach person receiving, directly or the plan or their position with the	indirectly, \$5,000 or more in t	otal compensation
-		(	(a) Enter name and EIN or	address (see instructions)		
CIGNA HE	ALTH AND LIFE INSU	JRANCE COM		ESTNUT STREET LPHIA, PA 19192		
59-103107	1					
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
12 14 53	CLAIMS ADMINISTRATION	150038	Yes □ No X	Yes □ No X		Yes □ No X

(a) Enter name and EIN or address (see instructions)

Yes No X

UNION SECURITY INSURANCE COMPANY

2323 GRANDE BOULEVARD KANSAS CITY, MO 64108

Yes No X

Yes No X

### 81-0170040

(b)	(c)	(d)	(e)	(f)	(g)	(h)
Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	Enter direct compensation paid by the plan. If none, enter -0	Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect	Did the service provider give you a formula instead of an amount or
12 14 53	CLAIMS ADMINISTRATION	80381	Yes No X	Yes No X	0	Yes No X
1		,	3) Enter name and EIN or			

(a) Enter name and EIN or address (see instructions)

(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	by the plan. If none,		(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	formula instead of an amount or estimated amount?
			Yes No	Yes No	(7)	Yes No

Page	3	-	2
<sup>2</sup> age	3	-	2

answered	I "Yes" to line 1a above	e, complete as many	entries as needed to list ea	r Indirect Compensation ich person receiving, directly or ne plan or their position with the	indirectly, \$5,000 or more in t	total compensation
			(a) Enter name and EIN or	address (see instructions)		
			,			
(b) Service Code(s)	Relationship to employer, employer organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	
			Yes No	Yes No		Yes No
			(a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	
			Yes No	Yes No		Yes No
<u> </u>		(	(a) Enter name and EIN or	address (see instructions)		
(b) Service Code(s)	Relationship to employer, employee organization, or person known to be a party-in-interest	(d) Enter direct compensation paid by the plan. If none, enter -0	(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)	(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?	(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0	(h) Did the service provider give you a formula instead of an amount or estimated amount?
			Yes No	Yes No		Yes No

3 If you reported on line 2 receipt of indirect compensation, other than eligible indirect compens	ation, by a service provider, and th	ne service provider is a fiduciary
or provides contract administrator, consulting, custodial, investment advisory, investment mar questions for (a) each source from whom the service provider received \$1,000 or more in indi provider gave you a formula used to determine the indirect compensation instead of an amou many entries as needed to report the required information for each source.	nagement, broker, or recordkeepin irect compensation and (b) each so	g services, answer the following ource for whom the service
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
	(coo mondono)	compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any ethe service provider's eligibility the indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(c) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any ethe service provider's eligibility the indirect compensation.
(a) Enter service provider name as it appears on line 2	(b) Service Codes (see instructions)	(C) Enter amount of indirect compensation
(d) Enter name and EIN (address) of source of indirect compensation	formula used to determine	compensation, including any the service provider's eligibility the indirect compensation.

Page <b>5-</b>
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[					
Part II Service Providers Who Fail or Refuse to Provide Information					
4 Provide, to the extent possible, the following information for each service provider who failed or refused to provide the information necessary to complete this Schedule.					
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide			
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide			
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide			
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide			
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(C) Describe the information that the service provider failed or refused to provide			
(a) Enter name and EIN or address of service provider (see instructions)	(b) Nature of Service Code(s)	(c) Describe the information that the service provider failed or refused to provide			

Page	6-
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Pa	Part III Termination Information on Accountants and Enrolled Actuaries (see instructions)			
а	Name:	(complete as many entries as needed)	<b>b</b> EIN:	
C	Positio		B EIIV.	
d	Addres		<b>e</b> Telephone:	
•	/ ladio		С госраново.	
Ex	olanatio	):		
			I	
<u>a</u>	Name:		b EIN:	
d d	Position Address		e Telephone:	
u	Addres	.5.	е тегерпопе.	
Ex	olanatio	n:		
а	Name:		<b>b</b> EIN:	
<u>C</u>	Positio			
d	Addres	SS:	e Telephone:	
Explanation:				
а	Name:		<b>b</b> EIN:	
С	Positio	n:		
d	Addres	ss:	<b>e</b> Telephone:	
Explanation:				
ᄓ	Jianalioi	i.		
а	Name:		b EIN:	
C	Positio			
d	Addres		e Telephone:	
Explanation:				